Department of Health and Mental Hygiene
Alcohol and Drug Abuse Administration
Nelson J. Sabatini, Secretary
Peter F. Luongo, Ph.D., Director

# OVERVIEW

**Introduction:**

What are we buying? Is it worth it?

To answer these questions the ADAA continues to work on moving the publicly-funded prevention, intervention and treatment system to a proactive agenda, emphasizing planning, information based decision making, increased use of technology and business practice reforms. The benefits are noticeable and comprise the baseline processes for the ADAA Performance Management system.

Some selected highlights of the past year:

- Established and deployed Regional Technical Advisory Teams
- Established performance measures for each grantee
- Introduced performance based compensation in ADAA procurement
- Completed electronic data reporting for all funded programs (By FY 2005 all certified programs will report electronically).
- Completed and published initial annual report, *Outlook and Outcomes.*

**Outcomes:**

- The number of patients treated in State-funded programs increased by 25 percent from FY 2000 to FY 2003. (33,981 to 42,600)
- Patients discharged from State-funded programs substantially reduced their substance use, by 93 percent for those completing treatment and by 46 percent for those not completing treatment.
- Patient employment increased by 17 percent overall during treatment.
- Patient arrest rates were cut nearly in half in outpatient treatment and by as much as 85 percent in residential programs.
- These changes persist over time. In FY 2003 ADAA completed a study tracking patients one-year post treatment through other State agency data bases Patient arrests declined and employment increased compared to before treatment. Further, treatment completers were 28 percent more likely to be employed and 54 percent less likely to be arrested than non-completers. Another follow-up study has been approved by the Institutional Review Board and ADAA is currently establishing agreements with State agencies to conduct the study.

**Budget Priorities:**

The FY 2005 allocation restores $ 1.8 million in FY 2004 cost contain ent and provides an additional $ 4 million for the expansion of residential programming to treat individuals involved in the juvenile justice or criminal justice systems.

The expansion includes the following services:

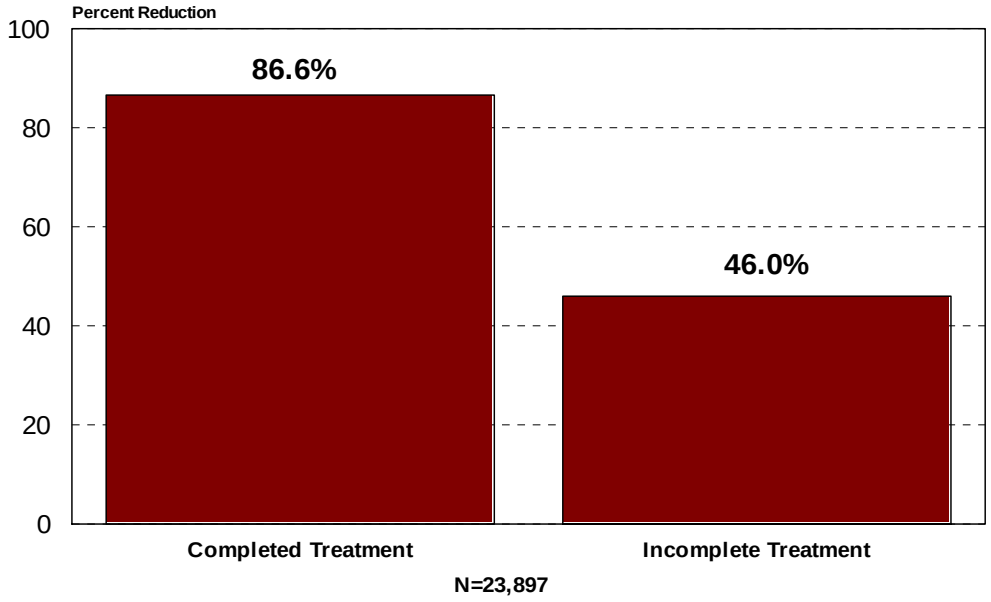
| **Adult Criminal Justice** | | |
|---|---|---|
| **Service** | **Beds** | **# Served Annually** |
| Therapeutic Community | 30 | 63 |
| Long Term Residential Co-occurring | 24 | 48 |
| Long Term Residential Women & Children | 7 women<br>2 children per women | 14 women |
| Total | 61 | 125 |

These services will be offered state-wide and combined with existing state-wide funds the ADAA administers, increases the state-wide Therapeutic Community capacity by 22%, (from 90 beds to 110), the co-occurring capacity by 160% (15 beds to 39) and the women and children's capacity by 18% (39 beds to 46). RFP's have been prepared to competitively procure the services. Consistent with the ADAA philosophy of performance management, the resultant contracts will include performance-based compensation.

| **Adolescent Juvenile Justice** | | |
|---|---|---|
| **Service** | **Beds** | **# Served Annually** |
| Detoxification | 1 | 60 |
| Intermediate Care | 9 | 88 |
| Crisis Stabilization | 2 | 150 |
| Halfway House | 6 | 12 |
| Total | 18 | 310 |

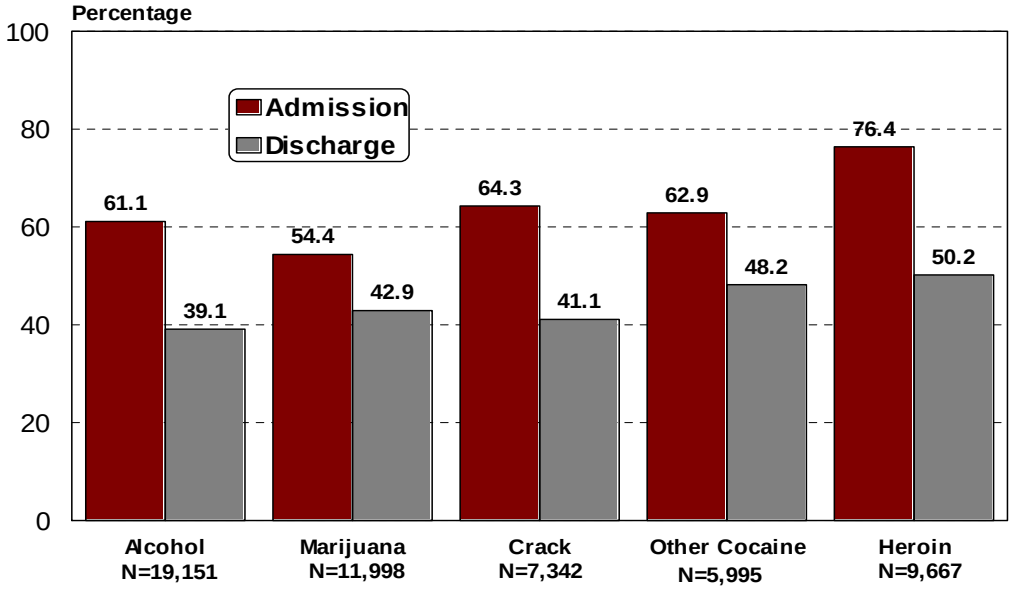
This is a significant expansion of adolescent residential services and includes the re-establishment of a halfway house in the Suburban Washington area and an innovative continuum of services including crisis stabilization in the Baltimore area.

## Completion of Treatment Reduces Days of Substance Use
## Percentage Reduction in Total Monthly Days of Use of the Primary Substance in Discharges from ADAA-Funded Treatment
## FY 2003



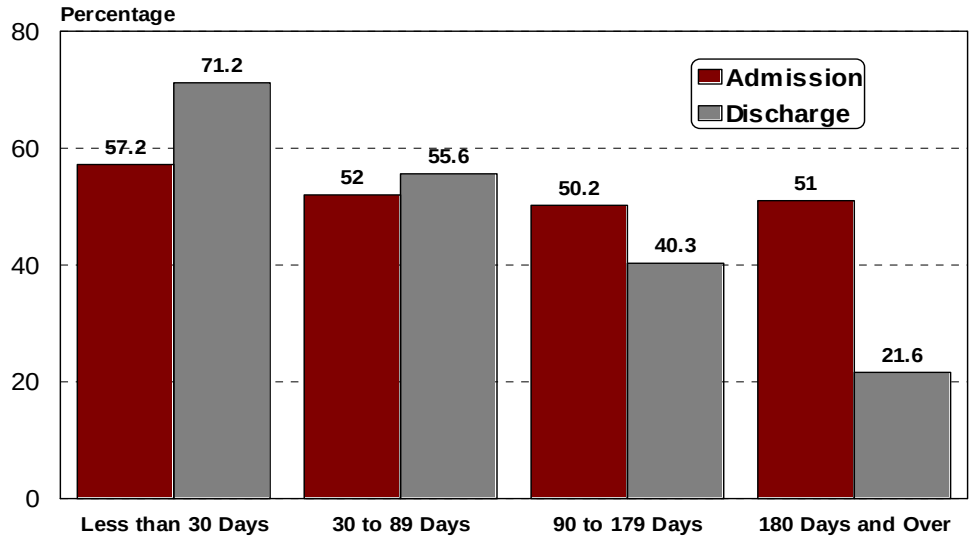

Note: Cases with unknown frequency of use at discharge are excluded.

## Treatment Reduces Substance Use
## Reduction in Use of Selected Substances from Admission to Discharge from ADAA-Funded Treatment
## FY 2003



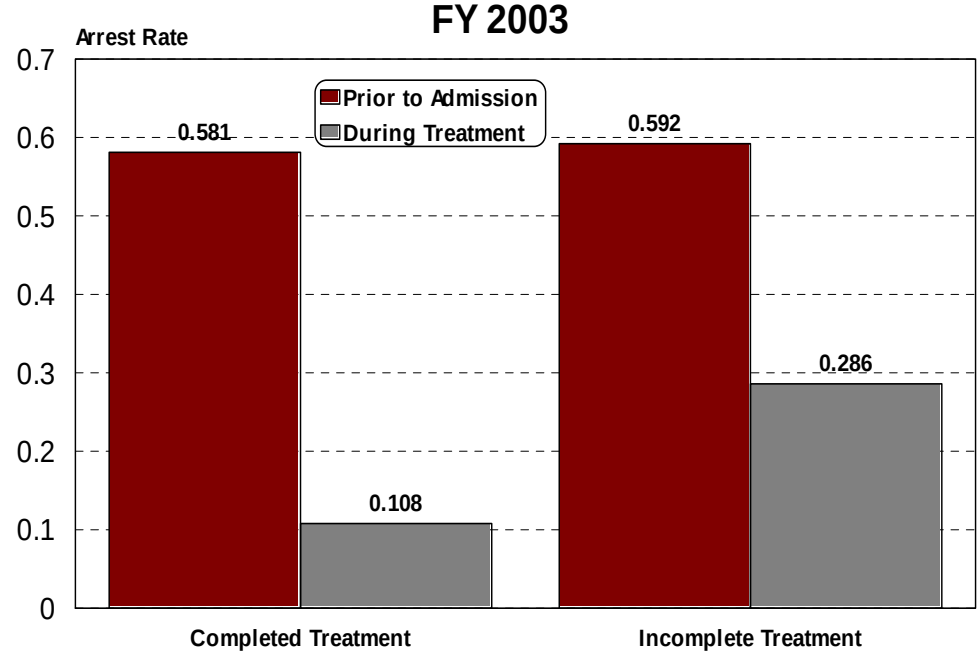

Note: Cases with unknown frequency at discharge are considered to be using.

## Time in Treatment Reduces Substance Use
## Reduction in Use of the Primary Substance from Admission to Discharge from ADAA-Funded Programs
## FY 2003

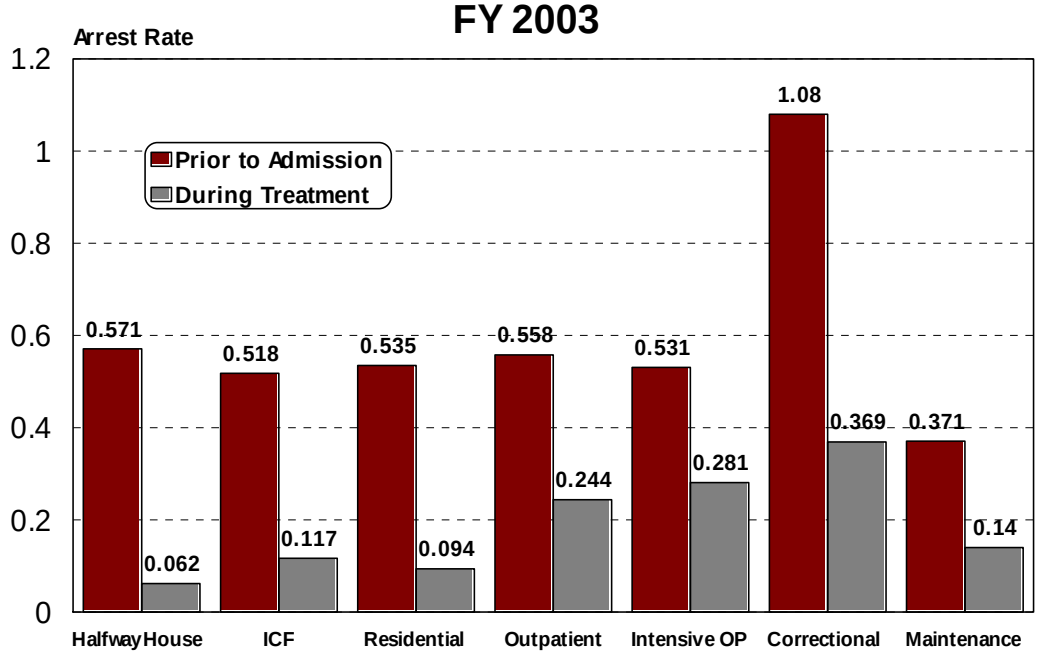



Note: Excludes detox, ICF and methadone discharges. Cases with unknown frequency at discharge are considered to be using.

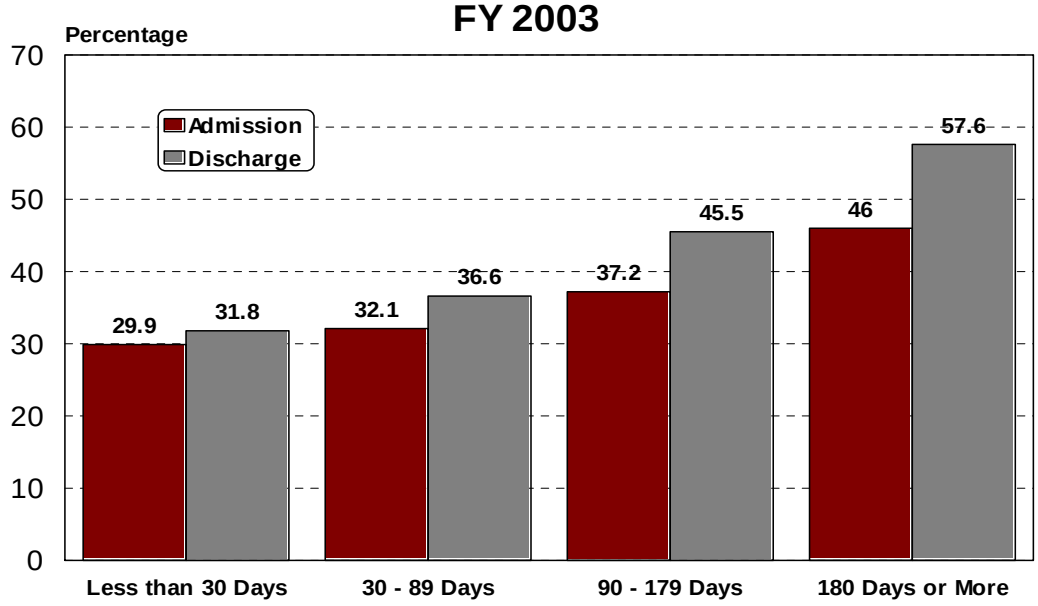
## Completion of Treatment Reduces Crime
## Arrest Rates During the Two Years Prior to Treatment and During Treatment in ADAA-Funded Programs
## FY 2003



## Treatment Reduces Crime
## Arrest Rates During the Two Years Prior to Treatment and During Treatment in ADAA-Funded Programs
## FY 2003

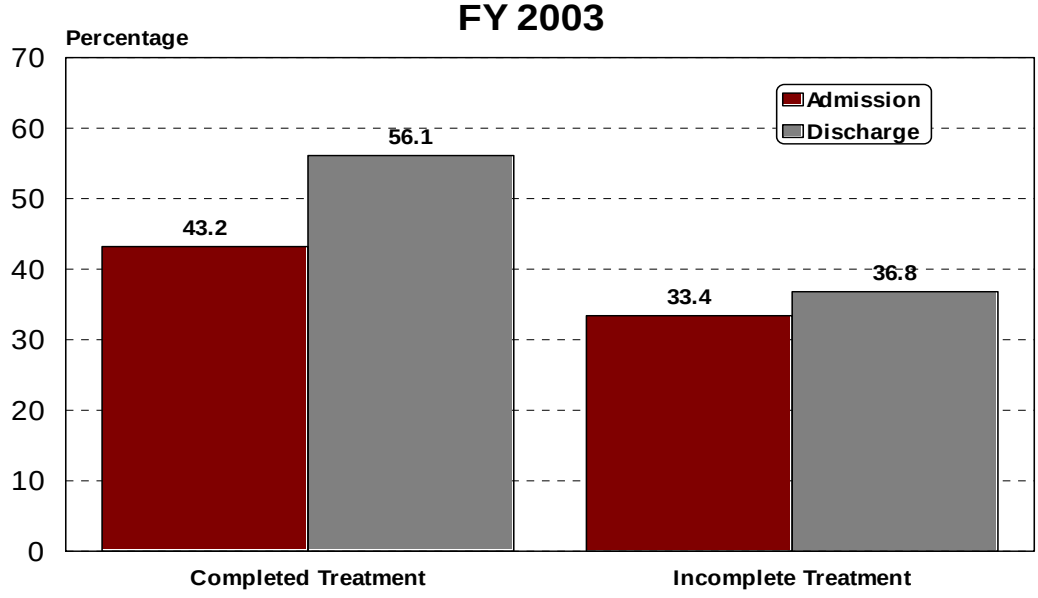



## Time in Treatment Increases Employment
## Changes in Percentage Employed from Admission to Discharge from ADAA-Funded Treatment
## FY 2003



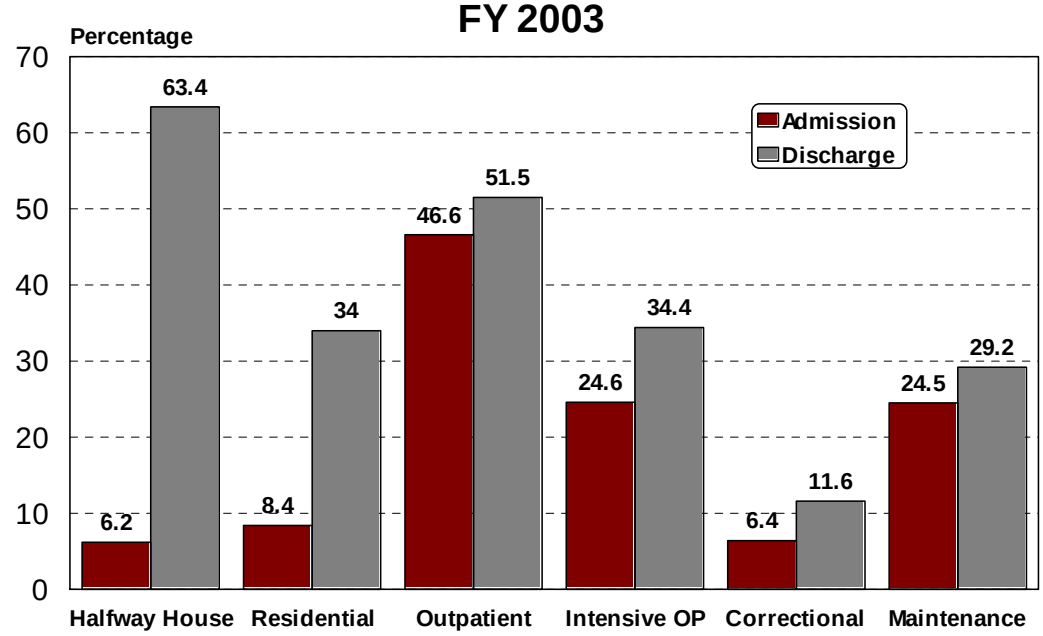

Note: Short-term residential and detoxification cases are excluded.

## Completion of Treatment Increases Employment
## Changes in Percentage Employed from Admission to Discharge from ADAA-Funded Treatment
## FY 2003

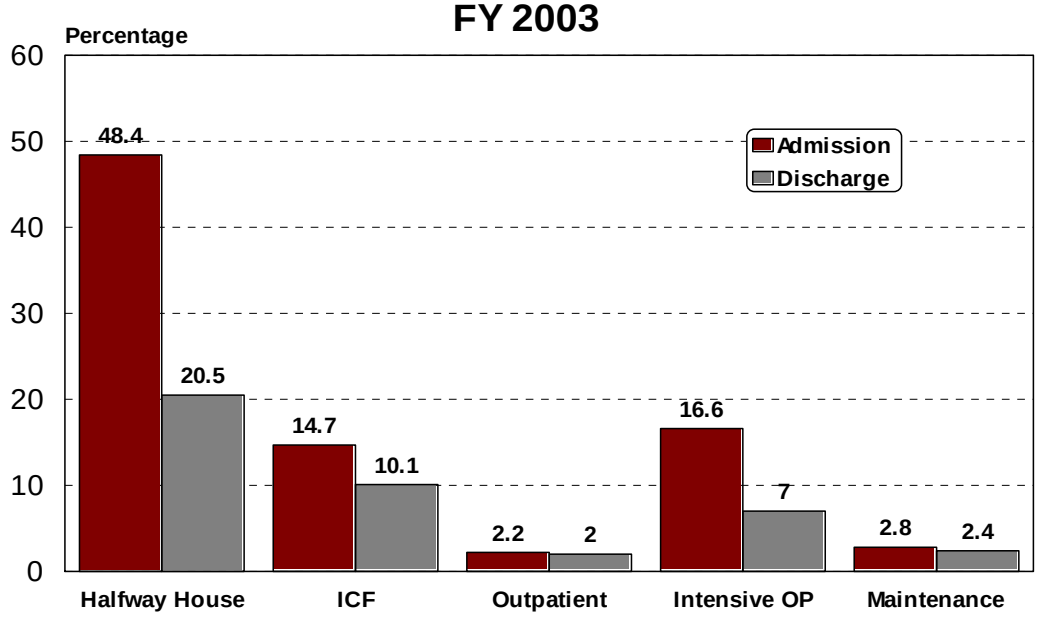



Note: Short-term residential and detoxification cases are excluded.

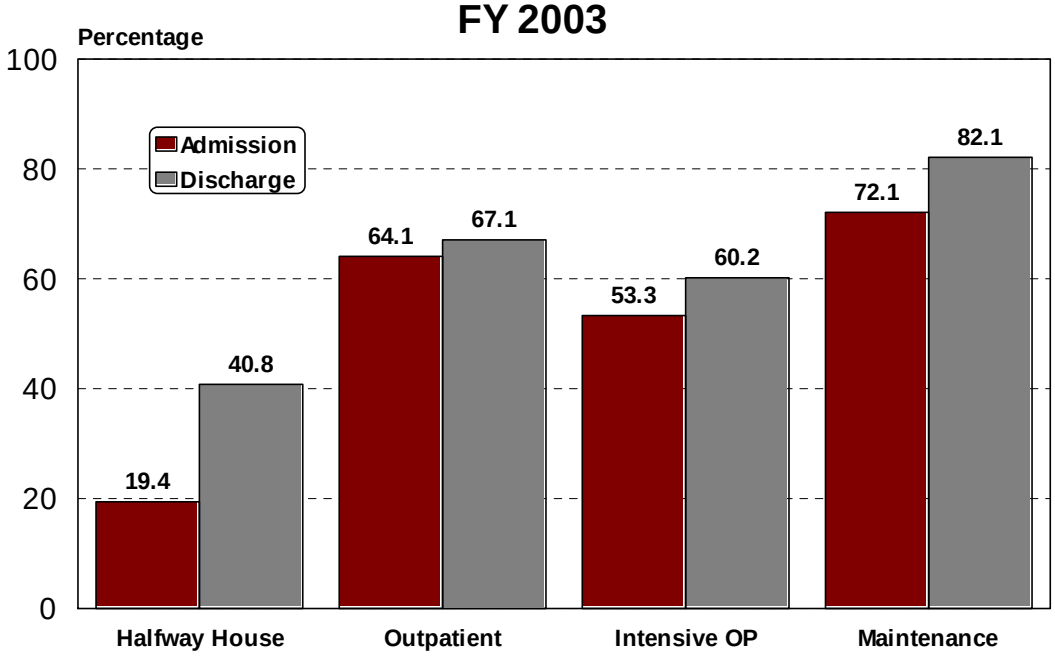
## Treatment Increases Employment
## Changes in Percentage Employed from Admission to Discharge from ADAA-Funded Treatment
## FY 2003



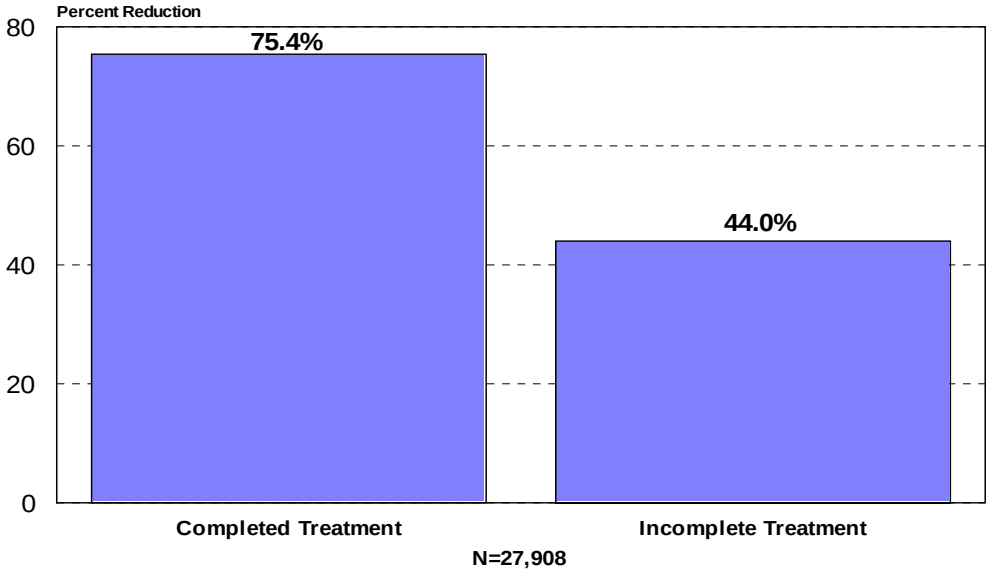
## Treatment Decreases Homelessness
## Changes in Percentage Homeless from Admission to Discharge from ADAA-Funded Treatment
## FY 2003




## Treatment Increases Independent Living
## Changes in Percentage Living Independently from Admission to Discharge from ADAA-Funded Programs
## FY 2003

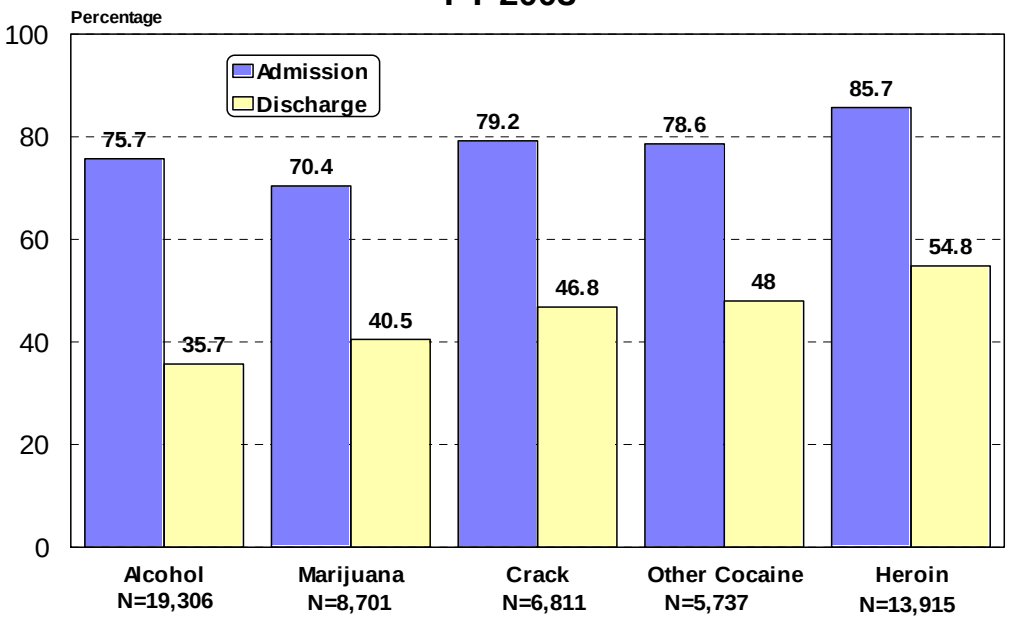


## Completion of Treatment Reduces Days of Substance Use
## Percentage Reduction in Total Monthly Days of Use of the Primary Substance in Non-Funded Treatment
## FY 2003



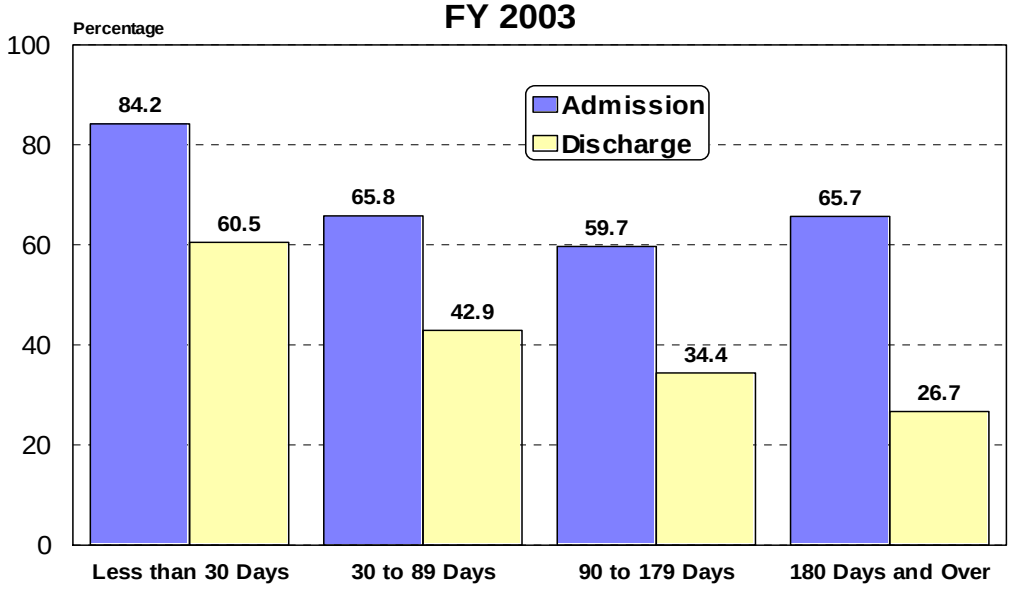

Note: Cases with unknown frequency of use at discharge are excluded.

## Treatment Reduces Substance Use
## Reduction in Use of Selected Substances from Admission to Discharge from Non-Funded Treatment
## FY 2003



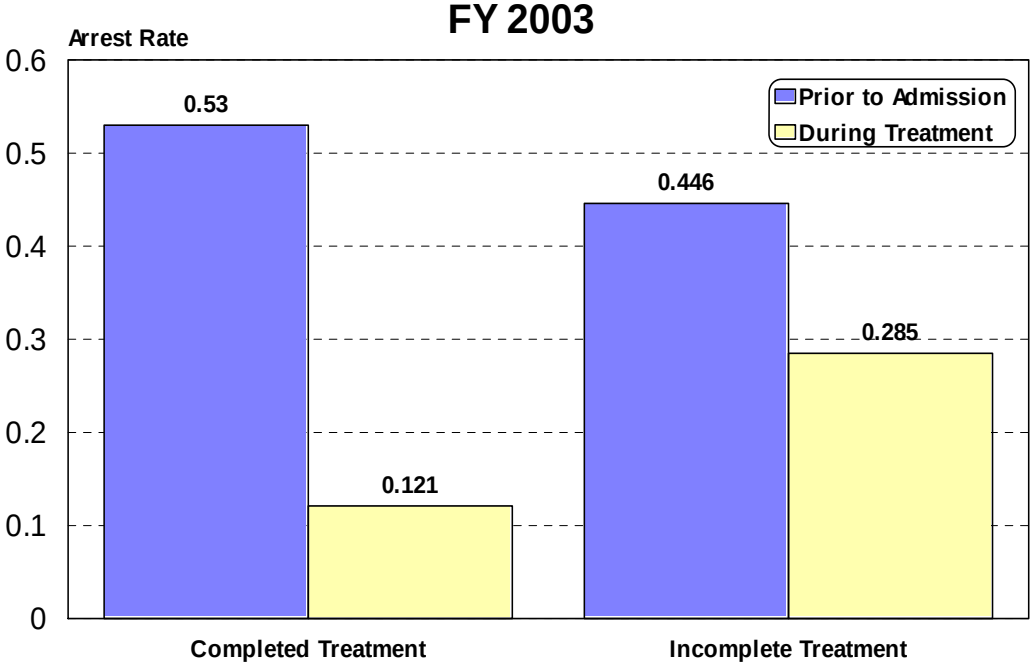

Note: Cases with unknown frequency at discharge are considered to be using.

## Time in Treatment Reduces Substance Use
## Reduction in Use of the Primary Substance from Admission to Discharge in Non-Funded Treatment
## FY 2003

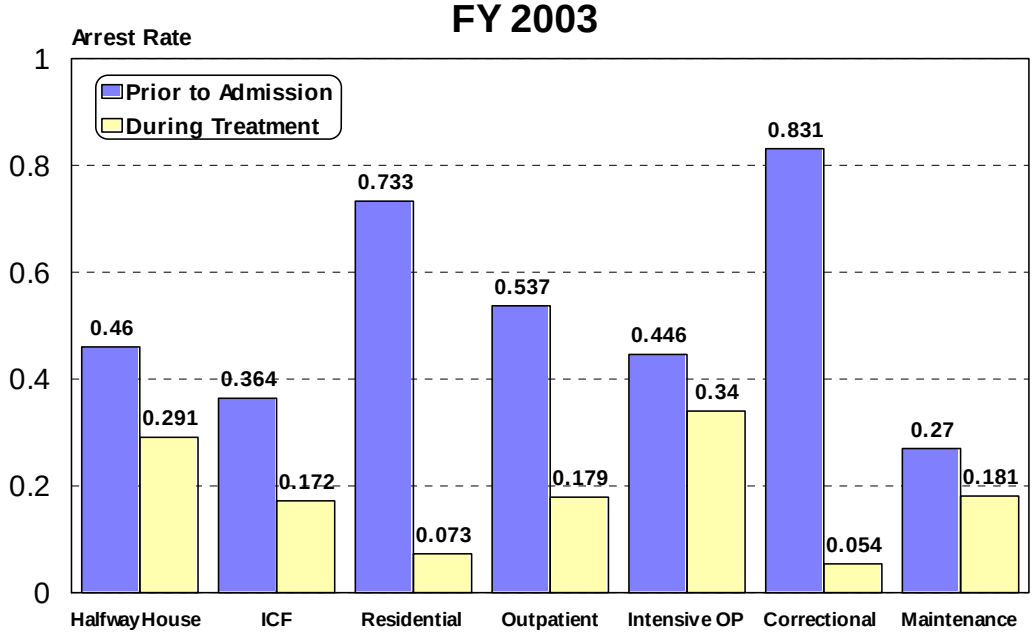



Note: Excludes detox, ICF and methadone discharges. Cases with unknown frequency at discharge are considered to be using.

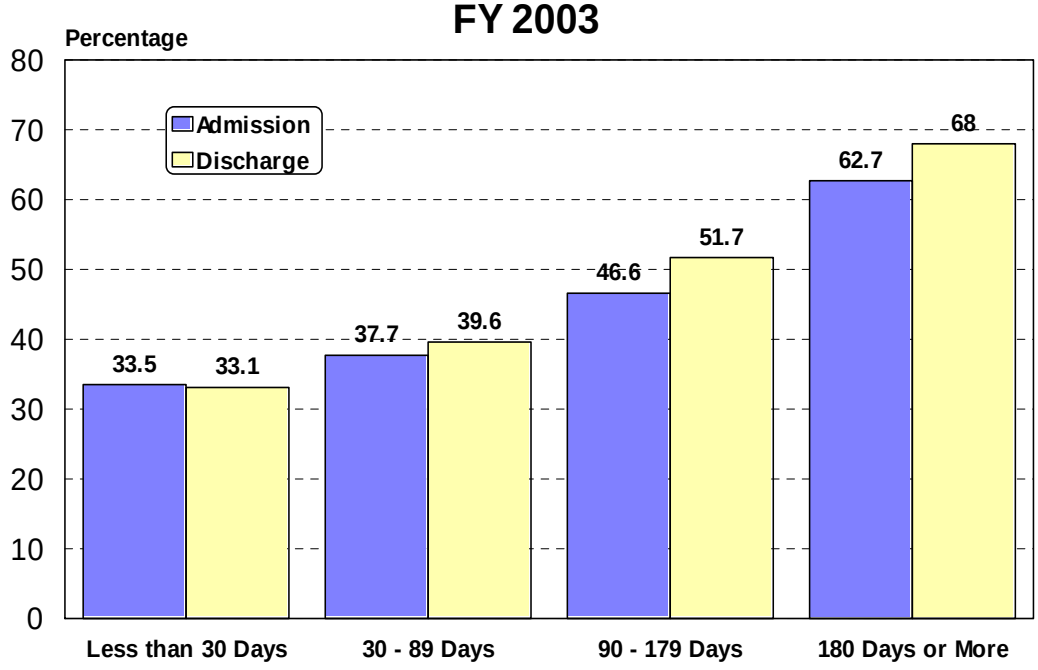
## Completion of Treatment Reduces Crime
## Arrest Rates During the Two Years Prior to Treatment and During Treatment in Non-Funded Programs
## FY 2003



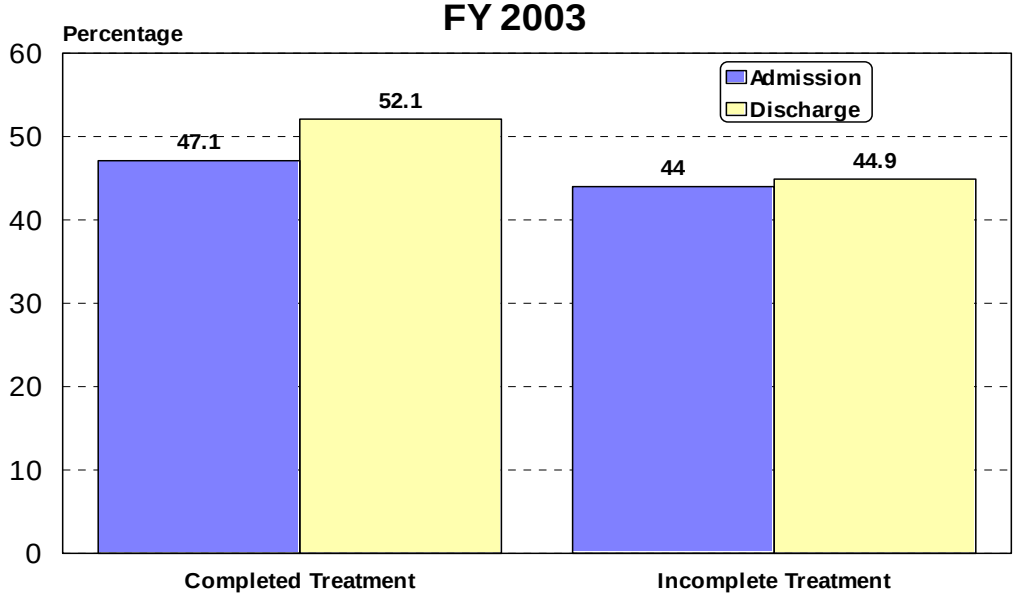
## Treatment Reduces Crime
## Arrest Rates During the Two Years Prior to Treatment and During Treatment in Non-Funded Programs
## FY 2003




## Time in Treatment Increases Employment
## Changes in Percentage Employed from Admission to Discharge from Non-Funded Treatment
## FY 2003

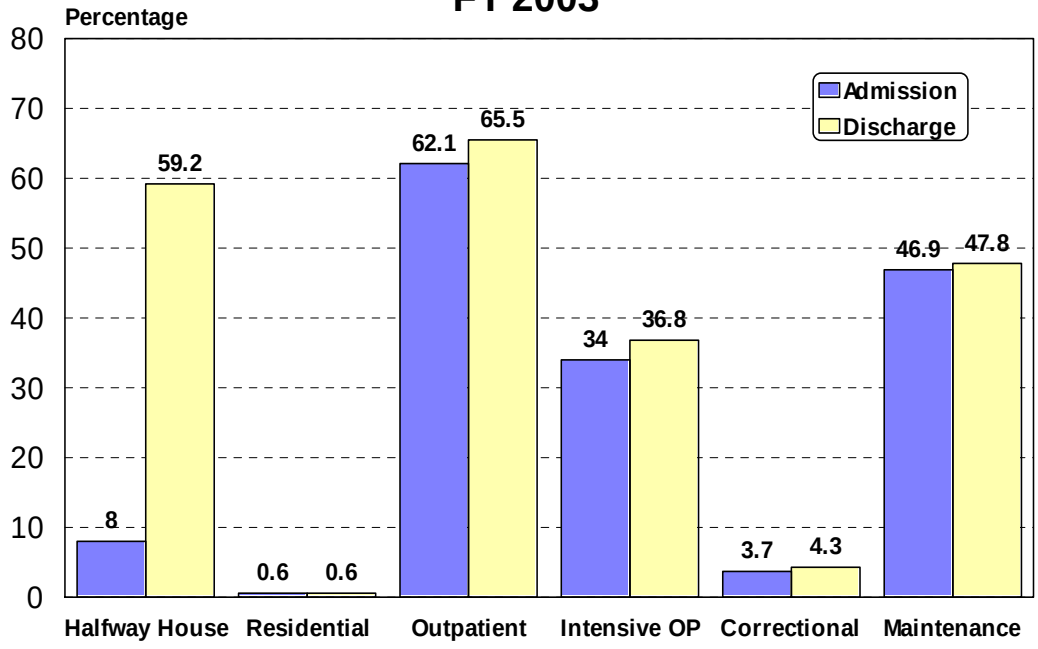


## Completion of Treatment Increases Employment
## Changes in Percentage Employed from Admission to Discharge from Non-Funded Programs
## FY 2003

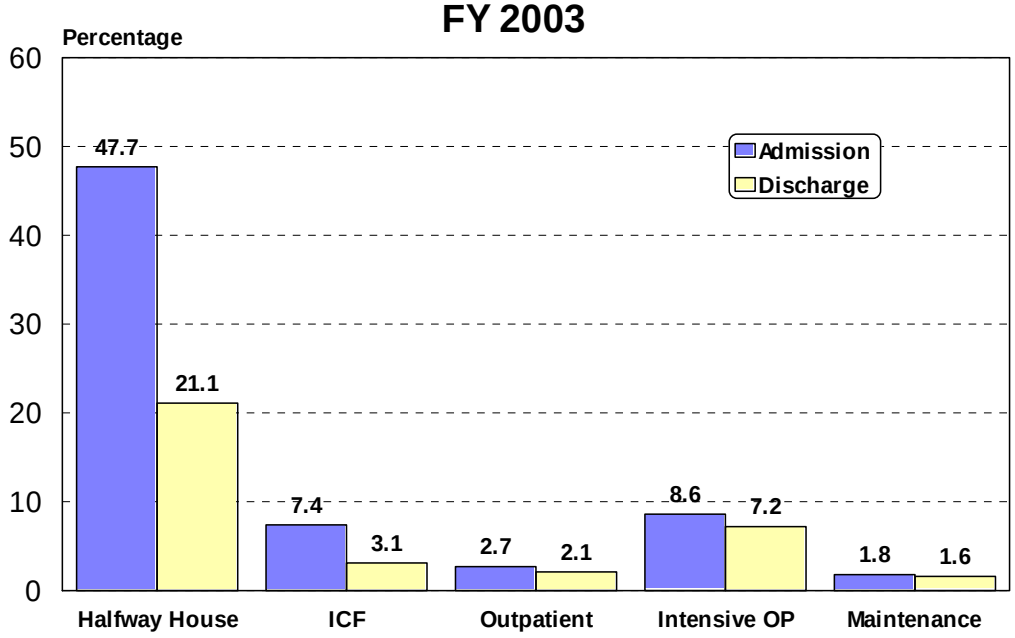



Note: Short-term residential and detoxification cases are excluded.

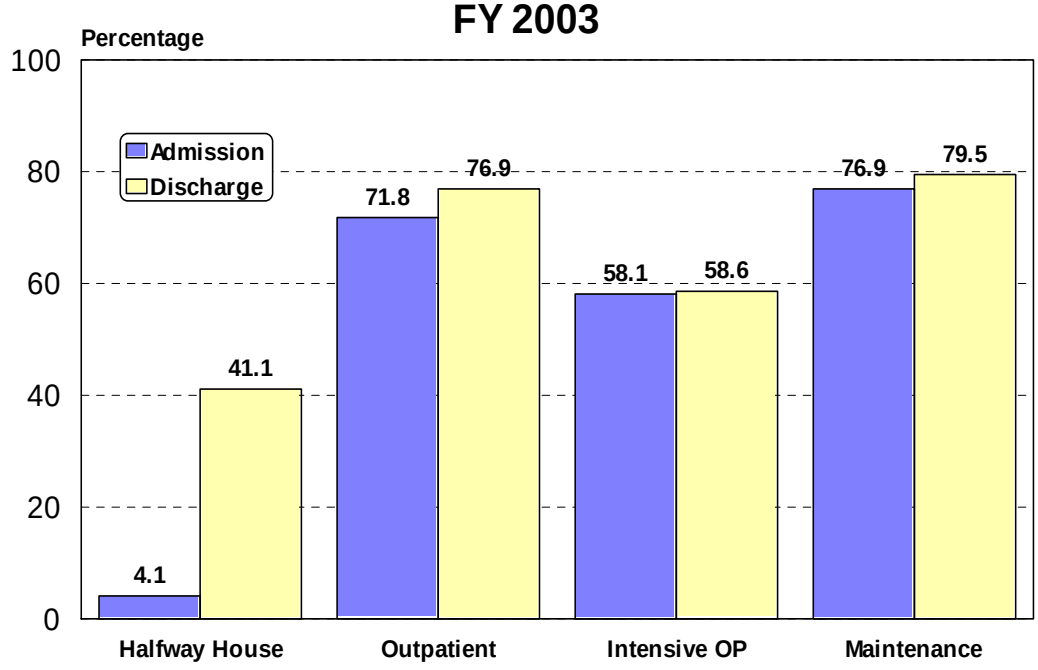
## Treatment Increases Employment
## Changes in Percentage Employed from Admission to Discharge from Non-Funded Treatment
## FY 2003



## Treatment Decreases Homelessness
## Changes in Percentage Homeless from Admission to Discharge from Non-Funded Treatment
## FY 2003




## Treatment Increases Independent Living
## Changes in Percentage Living Independently from Admission to Discharge from Non-Funded Treatment
## FY 2003



Department of Health and Mental Hygiene
Alcohol and Drug Abuse Administration
M00K0201

## Response to Recommended Actions

**Recommended Action 1:** **$ 1,991,280 GF**

Reduce funding to expand treatment services as an alternative to incarceration. The process by which the administration awards funds and local jurisdictions develop new treatment programs often takes several months. The reduction would reduce by half the amount provided for additional long-term treatment and outpatient services in recognition of systemic delays in program implementation.

**Response:**

The Department disagrees with the Recommended Action.

It is a fair criticism to say that in prior years poor planning and budgeting on both the state and local levels resulted in new program implementation delays. The ADAA has aggressively examined and altered the process by which funds are awarded and local jurisdictions develop new programs. The recommended adult treatment expansion is part of a state-wide procurement originating with the ADAA. Three Request for Proposals (RFPs) are written and complete and are under review. The resultant contracts will be executed prior to the end of FY 04 and have performance based compensation. The recommended adolescent treatment expansion has also benefited from this improved process. The facility for the halfway house is under the control of the local jurisdiction and meets licensing code standards, the jurisdiction's RFP for the services is written and the resultant contract will be executed by FY 05. The Intermediate Care and Detoxification services will be purchased under an existing purchase arrangement. In no case will there be a delay because of insufficient or inadequate physical space, the planning process accounted for adequate space.

The ADAA has properly and effectively responded to the past issue of delays in new program implementation and anticipates that the implementation of the recommended expansion will reflect that.

**Recommended Action 2:** **$ 1,842,440 GF**

Delete funds to partially restore Fiscal 2004 cost containment items.

**Response:**

The Department disagrees with the Recommended Action.

The ADAA took cost containments of $ 4,054,699 in FY 2004. Included in this was $2,010,319 in service reductions, primarily to jurisdictions. In keeping with the ADAA practice of local management of the local system, program reductions were taken at the jurisdiction's discretion. The FY 2005 ADAA budget respects the local management principle and jurisdictions will indicate their proposed use of the partial restoration of the funds in their FY 2005 ADAA grant application. That use is subject to the ADAA's approval.

The proposed reduction will result in a decrease of $ 1,842,440 in grant awards to the jurisdictions. This will result in discontinuing existing services. As a point of reference and to indicate the magnitude of the cut, a reduction of this size would eliminate approximately 450 outpatient treatment slots that serve an average of 900 patients a year, or eliminate all state-wide purchases of residential services for individuals with co-occurring substance use and psychiatric disorders. This proposed reduction would seriously and negatively affect local jurisdictions.

Department of Health and Mental Hygiene
Alcohol and Drug Abuse Administration
M00K0201

## Response to Issues

**Issue 1:**

The administration should comment on the status of eSAMIS development and implementation.

**Response:**

As of January 30, 2004, the eSAMIS online data collection system is in place and is on schedule for completion of the implementation phase. Of the 377 substance abuse treatment programs, 222 programs are currently reporting on the system. Ninety-nine (99) programs have notified ADAA they want to be connected to eSAMIS. These programs are in varying stages of readiness. The largest group of these programs is in Baltimore County. Baltimore County represents a large number of the 99 programs waiting to come online and they have recently notified ADAA that they will be abandoning their previous data system in favor of eSAMIS.

The next development is technical assistance and support to the jurisdictions on how to utilize the data to better manage patient care as well as monitor the performance of individual programs and the overall local system.

**Issue 2:**

The department should comment on the changes to treatment services proposed by the administration.

**Response:**

This is a proposal to increase the efficiency and effectiveness of the Maryland substance abuse treatment system. An adequate and competent system requires implementing evidence-based clinical and administrative practices. These practices must occur within practice and administrative structures that are sensible and sustainable. In some instances this should constitute changes to basic processes in both the health and social systems.[1]

It has been established that time in treatment is related to good outcomes.[2] Good outcomes include; a decrease in substance use, an increase in employment and a decrease

[1] For purposes of this discussion social systems include criminal justice, juvenile justice, child welfare, income maintenance etc.
[2] See, NIDA. (1999). *Principles of Drug Addiction Treatment, A Research-Based Guide* for a complete discussion of the topics in this section.

in criminality. Unfortunately, it is also true that retention in treatment is a significant problem. Nationwide dropout rates from outpatient care range from 40 to 60 percent of all admissions. However, individuals who stay in treatment the longest are those with some external motivation. Further, research shows that individuals completing treatment retain those gains in the long term.[3] Thus, for a state or jurisdiction interested in mitigating the social and health problems of addictions, there should be a keen interest in using the encounters with social systems as an opportunity to engage and retain individuals in treatment.

Maryland has demonstrated that encounters with the criminal or juvenile justice systems can be used to facilitate entry into treatment.[4] There are several examples of the simultaneous management of social control (broadly defined as justice system control) and treatment. Drug courts and graduated sanctions for probationers are promising recent developments. Drug courts are for a select and relatively limited number of offenders, while graduated sanctions is a strategy to manage social control and treatment with a larger group. They are not mutually exclusive approaches and rationally exploit the research findings that time in treatment is related to good outcome and individuals staying in treatment the longest are those with external pressure. Unfortunately, these approaches have rarely moved beyond pilot or idiosyncratic implementations. This is not due to the merit of the strategy to meld social controls and treatment. Rather, it is a reflection of the disconnect among policy, programs and planning.

This disconnect results in incomplete continua of care, and in some cases collections of programs clustered in similar geographic areas providing essentially the same services with limited access for justice involved clients. These are accidental systems of care. Intentional systems of care plan, estimate need, model the continuum of services needed in the jurisdiction and include as part of the "client mix" those social systems (or institutions) where addicted individuals appear. The individuals are not only clients, so too, are the other social systems. While there are instances where this occurs in Maryland, they are infrequent. Maryland's treatment system is, rightly so, locally managed. The down side is that absent an overall plan for care, accidental systems abound and haphazardly intersect with the justice systems.

The implicit policy and explicit practice of regarding individuals as criminal justice, juvenile justice or substance abuse clients, exclusively, and wrongly, assigns responsibility to the system that can first fix an administrative label to that person. The reality is that an individual with an addictive disorder typically appears as a client in multiple social systems.[5] Administratively labeling the individual by the system he or she appears ("DPP client", "DJS client" etc.) unintentionally limits the responsibility of the

[3] See, ADAA (2003). *Outlook and Outcomes;* UMD (2003), *TOPPS II, Long Term Drug Treatment Outcomes in Maryland.*

[4] This is highly variable across the state and subject to the distribution of resources as well as preferences of local courts. Most jurisdictions now have jail-based addiction treatment units, some drug treatment courts, and most at the very least, referral agreements with local DJS and DPP offices.

[5] The broader social system definition earlier referenced applies. A typical addicted individual receiving treatment in the public system tends to simultaneously be served by at least one other social system; criminal justice, juvenile justice, public health, income maintenance, social welfare, or education.

"other" systems for planning, budgeting and structuring operations for that individual's care.

The proposal by the administration is not the usual argument that if everyone only cooperates, collaborates and coordinates, shows good faith and good will, everything will turn out fine. The argument is to proactively *unify policy and practice on the legislative, planning, funding and operational levels to produce a more effective and efficient integration of addiction treatment and justice systems.*

This will improve the quality of Maryland's substance abuse system for all citizens.

**Issue 3:**

The administration should comment on the status of efforts to implement fiscal compliance measures recommended by the Office of Legislative Audits.

**Response:**

The ADAA has implemented a revised grant process for FY04 that accurately establishes treatment slot capacity by level of care for each jurisdiction. Treatment slot capacity will be updated each year and set as a condition of grant award. Local Health Officers must now acknowledge slot capacity related to each specific grant via a signature page retained in the grant file. Also, the ADAA has developed a database to record the number of treatment slots funded and is now developing the grants data management system to compare this information with actual treatment data. An automated data collection instrument (HATS) includes a profile though which programs can record treatment slots.

The Administration is implementing internal processes to perform quarterly reviews of program utilization data. Significant under-utilization will result in a consultation by the appropriate ADAA inter-disciplinary technical assistance team with the jurisdiction's Addiction Coordinator and/or Health Officer. If utilization does not reach appropriate levels, future grants will be adjusted accordingly. Interdisciplinary Teams within the ADAA have been established to review and monitor a variety of grant issues; e.g; grant reviews, budget modification requests, program data reporting (including utilization), and performance outcomes. Written policy to formalize this process is being developed.

ADAA staff conduct interdisciplinary field consultations and reviews to verify that providers are rendering services in accordance with grant agreements. Monitoring reports are being centralized in the master grants management file. Since field visits are typically staff labor-intensive, the use of information technology will be maximized in verification of treatment data and services provision.

Data from the ADAA Substance Abuse Management Information System (SAMIS) include privately funded programs. Specifically, outcome data are collected, validated, and analyzed by ADAA staff regarding Discharges by Treatment Type, Reason for Discharge, Discharge by Substance of Abuse, and Average Length of Stay. While not

presented as formal studies, these data elements represent outcome analysis that clearly includes privately funded programs and would meet the intent of the statute. These data are reported by the ADAA in the Treatment Outcomes section of *Outlook and Outcomes 2002* (printed July 2003). The ADAA will continue to use SAMIS data to evaluate the success and effectiveness of all Maryland treatment programs. The 2003 edition of *Outlook and Outcomes* will include a separate section presenting evaluation data regarding private programs.